

Services that are covered under the ESRD program and are contained in the composite rate reimbursement methodology, including any service furnished to a Medicare ESRD beneficiary that is directly related to that individual's dialysis, are excluded from coverage under the Medicare home health benefit.

(f) *Prosthetic devices.* Items that meet the requirements of § 410.36(a)(2) of this chapter for prosthetic devices covered under Part B are excluded from home health coverage. Catheters, catheter supplies, ostomy bags, and supplies relating to ostomy care are not considered prosthetic devices if furnished under a home health plan of care and are not subject to this exclusion from coverage.

(g) *Medical social services provided to family members.* Except as provided in § 409.45(c)(2), medical social services provided solely to members of the beneficiary's family and that are not incidental to covered medical social services being provided to the beneficiary are not covered.

[59 FR 65497, Dec. 20, 1994; 60 FR 39123, Aug. 1, 1995]

§ 409.50 Coinsurance for durable medical equipment (DME) furnished as a home health service.

The coinsurance liability of the beneficiary or other person for DME furnished as a home health service is 20 percent of the customary (insofar as reasonable) charge for the services.

[51 FR 41339, Nov. 14, 1986. Redesignated at 59 FR 65496, Dec. 20, 1994]

Subpart F—Scope of Hospital Insurance Benefits

§ 409.60 Benefit periods.

(a) *When benefit periods begin.* The initial benefit period begins on the day the beneficiary receives inpatient hospital, inpatient CAH, or SNF services for the first time after becoming entitled to hospital insurance. Thereafter, a new benefit period begins whenever the beneficiary receives inpatient hospital, inpatient CAH, or SNF services after he or she has ended a benefit period as described in paragraph (b) of this section.

(b) *When benefit periods end—*(1) A benefit period ends when a beneficiary has, for at least 60 consecutive days not been an inpatient in any of the following:

(i) A hospital that meets the requirements of section 1861(e)(1) of the Act.

(ii) A CAH that meets the requirements of section 1820 of the Act.

(iii) A SNF that meets the requirements of sections 1819(a)(1) or 1861(y) of the Act.

(2) For purposes of ending a benefit period, a beneficiary was an inpatient of a SNF if his or her care in the SNF met the skilled level of care requirements specified in § 409.31(b) (1) and (3).

(c) *Presumptions.* (1) For purposes of determining whether a beneficiary was an inpatient of a SNF under paragraph (b)(2) of this section—

(i) A beneficiary's care met the skilled level of care requirements if inpatient SNF claims were paid for those services under Medicare or Medicaid, unless:

(A) Such payments were made under § 405.330 or Medicaid administratively necessary days provisions which result in payment for care not meeting the skilled level of care requirements, or

(B) A Medicare denial and a Medicaid payment are made for the same period, in which case the presumption in paragraph (c)(2)(ii) of this section applies;

(ii) A beneficiary's care met the skilled level of care requirements if a SNF claim was paid under section 1879(e) of the Social Security Act;

(iii) A beneficiary's care did not meet the skilled level of care requirements if a SNF claim was paid for the services under § 405.330;

(iv) A beneficiary's care did not meet the skilled level of care requirements if a Medicaid SNF claim was denied on the grounds that the services were not at the skilled level of care (even if paid under applicable Medicaid administratively necessary days provisions which result in payment for care not meeting the skilled level of care requirements);

(2) For purposes of determining whether a beneficiary was an inpatient of a SNF under paragraph (b)(2) of this section a beneficiary's care in a SNF is presumed—

(i) To have met the skilled level of care requirements during any period